PRINTED: 10/13/2011 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	4B NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPLETED	
		155362	B. WIN			09/29/2	2011
			D. WIIV		T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			VIRGINIA PLACE		
GOLDEN	I LIVING CENTER-	MERRII I VII I E			RILLVILLE, IN46410		
					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000							
F0000	(PSR) to the Inv IN00094662 and on 09/01/11.  Complaints IN00094662- no IN00095771- no Survey dates: Se Facility number: Provider number: AIM number: I Survey Team: Regina Sanders, Census bed type SNF/NF: 150 Total: 150 Census payor ty Medicare: Medicaid: Other:	eptember 29, 2011 : 000253 r: 155362 100266660  RN	F0	0000	Preparation, submission an implementation of this Plan Correction does not constit admission of or agreement the facts and conclusions s forth on the survey report. Plan of Correction is preparand executed as a means t continuously improve the q of care and to comply with applicable state and federal regulatory requirements.	of ute an with et Our red o uality	
	•	ies reflect state findings					
	i incoc acmondici	ios romoco sumo munico			i		1

 $LABORATORY\ DIRECTOR'S\ OR\ PROVIDER/SUPPLIER\ REPRESENTATIVE'S\ SIGNATURE$ 

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QBDY12

Facility ID:

000253

If continuation sheet

(X6) DATE

TITLE

PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

I	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY  MPLETED  0/2011
	PROVIDER OR SUPPLIE		8800 V	ADDRESS, CITY, STATE, ZIP CO IRGINIA PLACE ILLVILLE, IN46410	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	cited in accorda	nce with 410 IAC 16.2.				

000253

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155362	B. WING			09/29/2	011
			р. үүлчс		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RGINIA PLACE		
GOLDEN	I LIVING CENTER-I	MERRILLVILLE			LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX			] 1	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0225	,	ot employ individuals who					
SS=D	-	guilty of abusing, neglecting,					
	•	dents by a court of law; or					
		entered into the State					
		/ concerning abuse, neglect, sidents or misappropriation					
		and report any knowledge it					
		a court of law against an					
		would indicate unfitness for					
		aide or other facility staff to					
	the State nurse aid	de registry or licensing					
	authorities.						
		nsure that all alleged					
		g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are rely to the administrator of					
		other officials in accordance					
		ough established procedures					
		tate survey and certification					
	agency).	•					
		ave evidence that all					
	_	are thoroughly investigated,					
	•	further potential abuse while					
	the investigation is	s in progress.					
	The results of all is	nvestigations must be					
		ministrator or his designated					
		d to other officials in					
		State law (including to the	1				
		certification agency) within 5	1				
	working days of th	e incident, and if the alleged	1				
		appropriate corrective	1				
	action must be tak						
	Based on record	review and interview, the	F02	225	1. Resident C investigation was		10/10/2011
	facility failed to	ensure an allegation of			completed on September 29, 20	11	
	verbal abuse was	reported to the			and the allegation of abuse was unsubstantiated. The employee	was	
	Administrator of	the facility in a timely			terminated related to failure to follow		
	manner, related t	o a CNA hearing			to facility abuse policy on Septe		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155362	B. WIN			09/29/20	011
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8		1	RGINIA PLACE		
	N LIVING CENTER-	MERRILLVILLE		1	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1	ig to a confused resident,			30, 2011.		
	1 ^	en repeatedly telling the			CNA #2 references were compl	eted	
		ip without intervening to			with positive results.	Cica	
	ensure the safety	of the resident for 1 of 3			<b>F</b>		
	residents review	ed for abuse in a sample			2. All residents have the potenti	ial to	
	of 5. (Resident #	C and CNA #1)			be affected by the same deficien		
					practice .Interview able residen		
	The facility also	failed to check			have been interviewed to ensure		
	1	n previous and/or current			further unreported or uninvestig allegations of abuse exist. All	;ated	
		d to not obtaining			incidents reports over the last 30	0	
		of 5 employees hired in			days were reviewed to ensure a		
	the past four mo				allegations of abuse were prope		
	line past roar mo	mins. (C1411/12)			identified and investigated. No	issues	
	Findings include				were noted.		
	Findings include	·			2 411 0 601 1 : :	,	
	1. D. :1 //C/				<ol><li>All Staff has been in-service the abuse policy and all steps</li></ol>	d on	
		record was reviewed on			involved in protecting the resident	ent	
		5 p.m. The resident's			and reporting as per policy. An		
	1 -	led, but were not limited			abuse post- test has been comp		
	to, dementia and	psychosis.			by staff to ensure that the inform		
					reviewed regarding abuse is		
	The resident's Si	gnificant Change			understood and proper steps are		
	Minimum Data S	Set assessment, dated			written to protect and report per		
	08/22/11, indicat	ted the resident had a			policy. The post- test will be ret in employee's personnel file. R		
	mental status sco	ore of 08 (moderately			will be reviewed by the Executi		
		nd no mood and behavior			Director/Designee and further		
	problems.				education will occur as needed.		
	A Nurses' Note	dated 09/26/11 at 7:33			These abuse post-tests will be u		
	•	"Resident becomes			as an ongoing tool to ensure tha	it staff	
	1 * '				understand their role in the prevention of abuse and residen	<sub>if</sub>	
	easily agitated and argumentative."				safety. This tool will be used in		
	A Niuma and Ninda	data d 00/26/11 -+ 10-26			Orientation as well as in conjun		
	•	dated 09/26/11 at 10:36			with the annual abuse in-service		
		'Resident agitated, and			schedule.		
	arguing with CN	A's, resident not					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155362	B. WIN			09/29/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	R			RGINIA PLACE		
GOLDEN	N LIVING CENTER-	MERRILLVILLE		1	LVILLE, IN46410		
				<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	cooperative in he	elping staff."			Current amplayee files have be	<b></b>	
					Current employee files have be audited for obtaining reference	en en	
	A, "Facility Incid	dent Reporting Form",			checks to ensure that our hiring		
	dated 09/28/11 a	t 2 p.m., indicated,			process was followed as per pol		
	"Overheard an	argument in the residents			Human resources staff were also		
		I someone shout to			educated on the requirement for		
	1 ' '	.' CNAdid not report			reference checks to be complete		
	1	today (Wednesday).			per policy. Director of Clinical		
					Education has instituted a check		
	Stated this occur	-			to initiate the reference checks		
	· '	dinner serviceCNA			end of the final interview with t	he	
	1	if argument was with res			applicant.		
	· ′	or from a (sic) employee			4. The Abuse post-tests will be		
	to resident since	she was only within			ongoing in our Orientation and		
	hearing range, no	ot visual"			annual abuse education process	. The	
					result of these tests will also be		
	An interview con	nducted by the			reviewed in QA committee to en	nsure	
		ith CNA #1, dated			that the process is upholding ou	r	
		ndicated, "overheard			abuse policy.		
	` '	speaking quietly, an aide					
					The Orientation checklis	st	
		ip the aide kept up			will be monitored by		
		ng her to shut up over			Executive Director or		
		ide was raising her			designee monthly and		
	voiceIt was ver	ry rude."			reviewed in QA committ	ee	
					for 6 months to ensure		
	During an interv	iew on 09/29/11 at 1 p.m.			100% compliance with		
	with the Adminis	strator, the Assistant			reference checks. After	6 l	
	Director of Nurs	ing (ADoN), and the RN			months, Executive Direct	ctor	
		ultant, the Administrator			or designee will random		
	_	1 was a new CNA. The			audit references for new	•	
					hired staff to ensure	,	
Administrator indicated CNA #1 did not tell her she wasn't sure if the person				checklist and employee	files		
		_			are maintained and in		
telling the resident to shut up was another resident or a staff member. She indicated					m		
					compliance. This randor	"	
	she assumed she	did not know because			audit process will be		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155362	B. WIN			09/29/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	R			RGINIA PLACE		
GOLDEN	N LIVING CENTER-	MERRILLVILLE		1	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		e the person telling the			ongoing.		
	resident to shut t	ip. She indicated she					
	educated the CN	A about the abuse policy					
	and ensuring the	resident's safety.					
		-					
	During an interv	iew on 09/29/11 at 3					
	1	dicated she was sure it					
	1 *	A who had shouted at the					
		ip. She indicated after					
		outed at the resident to					
	_	lent told the person not to					
		vay. CNA #1 indicated					
	said then the per	son told the resident two					
	to three more tin	nes to shut up. She					
	indicated she had	d not went to see if the					
	resident was safe	e. She indicated she					
		cked on the resident. She					
		d heard the ADoN talk to					
		out abuse and that is					
		d she should have					
	reported what sh	e had heard.					
	2. Review of Ch	NA #2's personnel file,					
	indicated the CN	A had been hired by the					
	facility on 07/05	/11. There was a lack of					
	1 -	o indicate the facility had					
	obtained referen	-					
		000 101 01111112.					
	During an interes	iew on 09/29/11 at 2:40					
	1 *	ducational Coordinator,					
		d not obtained references					
	on CNA #2.						
	This deficiency	was cited on 09/01/11.					

PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ í		NSTRUCTION 00	(X3) DATE S COMPL		
		155362	A. BUI B. WIN	ILDING NG		09/29/2	011
NAME OF PROVIDER OR	SUPPLIER		ļ.	1	DDRESS, CITY, STATE, ZIP CODE		
GOLDEN LIVING CI	ENTER-	MERRILLVILLE			LVILLE, IN46410		
PREFIX (EACH	DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULI LSC IDENTIFYING INFORMATION	ı	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
The facil systemic recurrence.  This fede number I 3.1-14(a) 3.1-28(c) 3.1-28(d) 4.1-28(d) 5.1-28(d) 5.1-2	y must collicies an ient, negopropriate ailed to on of ar reviewed of 5 (R 5 employ (CNA)	d to implement a correction to prevent relates to complaint 4662 and IN00095771.  Revelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. review and interview, the follow their policy for Administrator a allegation of verbal a for a resident, and aff member for 1 of 3 ed for abuse allegations in esident #C and CNA #1) by ee records reviewed for #2).	F(	0226	1. Resident C investigation was completed on September 29, 20 and the allegation of abuse was unsubstantiated. The employee terminated related to failure to foot facility abuse policy on Septer 30, 2011.  CNA #2 references were complewith positive results.  2. All residents have the potential be affected by the same deficient practice. Interview able resident	was collow ember eted al to at	10/10/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QBDY12 Facility ID: 000253

If continuation sheet Page 7 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	DING	00	COMPL	ETED
		155362	A. BUII B. WIN	LDING		09/29/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			IRGINIA PLACE		
GOI DEN	N LIVING CENTER-	MERRILLVILLE		1	LLVILLE, IN46410		
			_				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
					have been interviewed to ensur		
	1. Resident #C's	record was reviewed on			further unreported or uninvesti	gated	
	09/29/11 at 12:0	5 p.m. The resident's			allegations of abuse exist. All incidents reports over the last 3	80	
	diagnoses includ	led, but were not limited			days were reviewed to ensure a		
	to, dementia and	psychosis.			allegations of abuse were prope		
		1 3			identified and investigated. No	-	
	The resident's Si	gnificant Change			were noted.		
	1	-					
		Set assessment, dated			3. All Staff has been in-service	ed on	
		ted the resident had a			the abuse policy and all steps		
		ore of 08 (moderately			involved in protecting the resid		
	impaired) and ha	ad no mood and behavior			and reporting as per policy. A		
	problems.				abuse post- test has been comp		
					by staff to ensure that the infor reviewed regarding abuse is	mation	
	A Nurses' Note,	dated 09/26/11 at 7:33			understood and proper steps ar	e	
	1	"Resident becomes			written to protect and report pe		
	1 * '	nd argumentative."			policy. The post- test will be re		
	casily agreated a	nd argumentative.			in employee's personnel file. F		
	A NI was al NI at a	1.4.100/26/11 -4 10:26			will be reviewed by the Execut	ive	
	1	dated 09/26/11 at 10:36			Director/Designee and further		
	1	"Resident agitated, and			education will occur as needed		
	1 ~ ~	A's, resident not					
	cooperative in h	elping staff."			These abuse post-tests will be		
					as an ongoing tool to ensure th understand their role in the	at staff	
	A, "Facility Inci	dent Reporting Form",			prevention of abuse and reside	nt	
	dated 09/28/11 a	at 2 p.m., indicated,			safety. This tool will be used in	-	
		argument in the residents			Orientation as well as in conju		
	1	d someone shout to			with the annual abuse in-service		
	1 ' '	.' CNAdid not report			schedule.		
	1	•					
	1	l today (Wednesday).			Current employee files have be		
	Stated this occur	-			audited for obtaining reference		
	1 '	dinner serviceCNA			checks to ensure that our hiring	-	
	could not verify	if argument was with res			process was followed as per po	-	
	(resident) to res	or from a (sic) employee			Human resources staff were als educated on the requirement for		
	to resident since	she was only within			reference checks to be complet		
	hearing range, n	-			reference enceks to be complete	ou as	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155362	B. WIN			011	
NAME OF I					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			8800 VI	RGINIA PLACE		
	N LIVING CENTER-				LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAU	REGULATORT OR	LSC IDENTIFTING INFORMATION)	+	IAU	per policy. Director of Clinical		DATE
		1 ( 11 (1			Education has instituted a check	list	
	An interview con				to initiate the reference checks		
		ith CNA #1, dated			end of the final interview with t	he	
		ndicated, "overheard			applicant.		
	1 '	speaking quietly, an aide					
	1	p the aide kept up			4. The Abuse post-tests will be		
		ng her to shut up over			ongoing in our Orientation and annual abuse education process	The	
	and overThis a	ide was raising her			result of these tests will also be	. THC	
	voiceIt was ver	ry rude."			reviewed in QA committee to en	nsure	
					that the process is upholding ou	r	
	During an interv	iew on 09/29/11 at 1			abuse policy.		
	p.m., with the Ac	dministrator, the Assistant					
	Director of Nurs	ing (ADoN), and the RN			The Orientation checklis	st	
	Corporate Consu	ultant, the Administrator			will be monitored by		
	indicated CNA #	1 was a new CNA. The			Executive Director or		
	Administrator in	dicated CNA #1 did not			designee monthly and		
		't sure if the person			reviewed in QA committ	ee	
		nt to shut up was another			for 6 months to ensure		
	1	f member. She indicated			100% compliance with	_	
		did not know because			reference checks. After		
		e the person telling the			months, Executive Direct		
		ip. She indicated she			or designee will random	•	
		A about the abuse policy			audit references for new	/ly	
					hired staff to ensure		
	and ensuring the	resident's safety.			checklist and employee	files	
	During on into-	iew on 09/29/11 at 3			are maintained and in		
	~				compliance. This randor	n	
	_	dicated she was sure it  A who had shouted at the			audit process will be		
		_ ,,			ongoing.		
	1	ip. She indicated after					
		outed at the resident to					
	1	lent told the person not to					
talk to her that way. CNA #1 indicated							
	1	son told the resident two					
	to three more tin	nes to shut up. She					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155362	B. WIN			09/29/2	011
			-		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIEF	C		8800 VI	RGINIA PLACE		
	I LIVING CENTER-				LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DLI ICILIACI)		DATE
		d not went to see if the					
		e. She indicated she					
		cked on the resident. She					
		d heard the ADoN talk to					
		out abuse and that is					
		d she should have					
	reported what sh	e had heard.					
	2. Review of Ch	NA #2's personnel file,					
		A had been hired by the					
		/11. There was a lack of					
	1 *	o indicate the facility had					
	obtained referen	-					
	During an interv	iew on 09/29/11 at 2:4 0					
	~	ducational Coordinator,					
	* ·	d not obtained references					
		e indicated the facility's					
		l not been followed.					
	A facility policy	, titled,, "Verification of					
	_	Alleged Mistreatment,					
	Abuse, Neglect,	Injuries of Unknown					
		ppropriation of Resident					
	1 2	ne", dated 01/11, and					
	received as curre	ent from the					
	Administrator, in	ndicated, "It is the					
	responsibility of	all employees to					
	immediately rep	ort any alleged violation					
	of abuseIt is a	lso the policy of this					
	center to take ap	propriate steps to ensure					
	that all alleged v	iolationsare reported					
ļ	1	he executive director of					
	the centerStaff	Screening All applicants					

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362		ILDING	00	COMPL 09/29/2	ETED
	PROVIDER OR SUPPLIER		p. WII	STREET A 8800 VII	DDRESS, CITY, STATE, ZIP CODE RGINIA PLACE LVILLE, IN46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) in the center shall at a		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	minimum, have to checks conducted the current and/of employerReside employee or farm ED (Executive Demployee on immediately not investigationIf visitor or friend, to visit the resided is completedResulting who suspects an immediately not indesignee"  This deficiency of the facility failed systemic plan of recurrence.	ily, friend or visitor-the birector) places the mediate investigatory while completing the it is a family member, they will not be allowed ent until the investigation eporting: any employee alleged violation fies the ED, or  was cited on 09/01/11. d to implement a correction to prevent					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155362  NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-MERRILLVILLE			8800 V	ONSTRUCTION  00  ADDRESS, CITY, STATE, ZIP CODE  IRGINIA PLACE  ILLVILLE, IN46410	(X3) DATE SURVEY COMPLETED 09/29/2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QBDY12 Facility ID:

ID: 000253

If continuation sheet